

reviews

BOOKS • CD ROMS • ART • WEBSITES • MEDIA • PERSONAL VIEWS • SOUNDINGS



Trauma Africa

BBC 1, Thursdays at 9 pm until 21 July

Rating: ★☆☆

According to Noam Chomsky, whom I understand ranks with Karl Marx, Shakespeare, and the Bible as one of the 10 most quoted sources in the humanities, the responsibility of intellectuals is to tell the truth and expose lies. Why not judge a television documentary using the same criteria? So how does the three part series *Trauma Africa* line up?

As someone who was scared witless by a 1970s documentary on climate change (the ice age cometh) that grimly forecast that an ice age was imminent, only to discover years later that global temperatures are heading in the opposite direction, I am sceptical about documentaries. But no problem this time. Trauma rates in Africa are among the highest in the world. According to the World Health Organization, each year there are more than 200 000 road traffic deaths in Africa and perhaps 20 to 30 times as many people seriously injured. And trauma in Africa is definitely getting hotter, with injury rates predicted to increase by around 80% by 2020. Violence—whether every day thug-gery (like the man seen in this documentary being shot in his car), or state violence (like the riot police seen shooting a union activist in the face)—is, of course, endemic.

The screening of *Trauma Africa* was also well timed—only days after the Live 8 jamboree in cities around the world and the G8 summit, where a small group of white men quibbled over the future of the disenfranchised millions on the dark continent.

In evidential terms the first episode of *Trauma Africa* (the only episode available on the preview tape) was a fact-free serving. Documentaries of the past would use human interest to locate facts in their human context, to talk to the heart as well as the head. Not this one. This was infotainment at its worst. An hour of broken bones, torn flesh, and macho doctors will leave you no better informed about how many people in Africa experience violence or road traffic injuries, what sort of people they are, whether they are rich or poor, or how many

survive and for how long. More importantly, we are no better off in understanding why. Granted, we were spared the details of the interpersonal relationships of the emergency department staff, but apart from that there was little to set the first part of *Trauma Africa* above mind numbing soaps such as *ER* and *Casualty*.

I can remember when television documentaries would raise the political consciousness of the British public. The thalidomide scandal was presented as a human interest story about damaged children, but we also learnt how the pharmaceutical companies put profit before people and lied to protect their interests. Perhaps filmmakers today think the viewing public is too stupid to understand political issues.

So lots of people are being injured on Africa's roads. What are the G8 and the British government doing about this? For a start the World Bank, which provides the loans that pay for much of Africa's transport infrastructure, has decided that a consortium of motor manufacturers and brewers should take the lead on road safety in Africa. This is rather like putting the tobacco industry in charge of smoking cessation programmes. Perhaps viewers would be interested to know that their Department for International Development is giving its meagre contribution to global road safety—and this is British taxpayers' money—to this consortium. They may also be interested to know that the prime minister, Tony Blair, wants to build more roads in Africa and to increase road traffic fivefold because he thinks that this will allow Africa to trade its way out of poverty. A British trauma surgeon working in Malawi and writing in last week's *BMJ* is sceptical about this. He thinks it will increase road traffic injuries and laments the lack of resources going into road safety (*BMJ* 2005;331:46-7).

A misleading impression that viewers may have from watching *Trauma Africa* is that trauma is exciting. Over the past five years, as the clinical coordinator of the Medical Research Council CRASH trial (www.crash.lshtm.ac.uk/), I have visited emergency departments all over the developing world. Without exception, the doctors and nurses I met were tired, disgusted, and frustrated by the endless barrage of bleeding humanity that piled through the department doors. But then several of the doctors featured in the first part of *Trauma Africa* were not Africans. Some were British doctors honing up their trauma skills. One pointed out that doctors needed to do 30 trauma laparotomies to make the grade in



Compassionate and able: paramedic Louis Phampe

trauma surgery. This can take three years in the north but only three months in Johannesburg.

Another potential misconception is that all hospitals in Africa look like the ones shown. No way. WHO has recently come up with the most basic list of trauma care equipment that African hospitals should have, and many hospitals in Africa do not even have items on this list. In Ghana, for example, rolled up towels are used to stabilise the spine when cervical instability is suspected. Similarly, the paramedics shown in *Trauma Africa* drove around in flashy ambulances, but in much of Africa patients come to hospital in taxis or in the back of trucks, if they come to hospital at all.

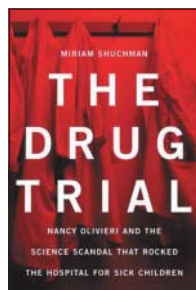
But perhaps the politics was subliminal. After all, we could see for ourselves that the casualties were poor and black, and perhaps it was meant to be ironic that we discover in the closing minutes that the compassionate and able black paramedic featured is now in London. Perhaps he will get a job working in the NHS?

Ian Roberts *professor of epidemiology and population health, London School of Hygiene and Tropical Medicine*
Ian.Roberts@lshtm.ac.uk

Items reviewed are rated on a 4 star scale (4=excellent)

The Drug Trial: Nancy Olivieri and the Science Scandal that Rocked the Hospital for Sick Children

Miriam Shuchman



Random House Canada,
\$C34.95, pp 464
ISBN 0 679 31084 3
www.randomhouse.ca/

Rating: ★☆☆☆

The facts go something like this. In 1996 Nancy Olivieri, a haematologist working at the Hospital for Sick Children in Toronto, came to believe that an experimental iron chelating drug (deferiprone) that she was trialling in patients with thalassaemia was losing efficacy and causing serious adverse effects. Apotex, the company that made the drug and that was partly funding the trial, disagreed. When Olivieri indicated that she intended to inform participants of her concerns, Apotex terminated the trials and withdrew financial support. They invoked a confidentiality agreement in the research contract and threatened legal action if she made the findings public. Undeterred, Olivieri presented her results at a scientific meeting and submitted them for publication.

Events after the dispute between Olivieri and Apotex showed deep divisions and personal animosity within the academic community in which she worked. Many of her colleagues were, to say the least, unsupportive. An internal inquiry set up by the hospital authorities found her to have been at fault in the way she handled events after the termination of the trial. (The inquiry was later judged to be flawed in the evidence it heard and in the conclusions it reached.) She was fired from her position as director of the haemoglobinopathy research programme and referred to the medical licensing board of Ontario for research misconduct.

All this is well known. The affair was widely covered in the news media and the medical press. The usual version of the story casts Olivieri as heroine, a plucky whistleblower who, regardless of her own interests, did the right thing. Apotex is cast as the villain: a capitalist monster. The University of Toronto and the Hospital for Sick Children have been seen as afraid that, if they supported Olivieri, a multimillion dollar donation to create a biomedical research

facility that they were negotiating with Apotex would fall through.

Olivieri's supporters mostly take the view that the central issue is one of academic freedom: that it doesn't matter whether she was right or wrong or whether she was a congenial or disagreeable colleague. The important thing was that she was concerned enough about the safety of the drug to convey her doubts to a scientific meeting and to a peer reviewed journal so that members of the medical community could judge for themselves. Some people reckon that the main lesson to be learnt is that if academic freedom is to be maintained then collaborations between industry and universities need to be better managed. Researchers and their institutions need to examine the conditions under which funding is provided, to think about potential conflicts, and to set up ways to resolve them before they happen. They may well be right. Indeed, it is hard for an outsider to avoid thinking that had an independent data monitoring committee been in place the whole business might have been avoided.

In a commentary published in the Canadian Medical Association's journal (*CMAJ* 2001;165:783-5), Steven Lewis and colleagues memorably described the negotiation of contracts between industry and universities as dancing with a porcupine—something to be undertaken only with prudence and the right precautions—but perhaps unavoidable in circumstances where few universities can afford to turn down commercial partnerships. Others believe the roles of university and industry to be in fundamental conflict: one is, or at least ought to be, concerned with the pursuit of knowledge, while the other's business is making money for shareholders. These aims are irreconcilable, and universities should realise that when commercial companies make substantial donations they are likely to expect to gain substantial influence.

The Olivieri story raises other questions too. Why are whistleblowers treated so badly by the institutions in which they work? What is it about the structures, vested interests, or collective psychology of these institutions that leads, at best, to whistleblowers being marginalised and often to them being vilified and dismissed? Another is about the failure of research ethics committees to consider how the financial and legal arrangements between researchers and pharmaceutical companies impinge on the safety and rights of trial participants. And, most fundamental of all, how should society fund biomedical research institutions and biomedical research?

It is disappointing that Schuchman's book hardly touches on these issues. Instead, it retells the story from a worm's eye view,

dwelling on the personalities of the people involved, what they said about each other, who was sleeping with whom, and the tricks they got up to to blacken each other's reputations. At the beginning the author tells us that while researching the book she discovered information that made her abandon the idea that she was telling a straightforward story of the machinations of a powerful company exposed by a whistleblower. But 400 pages later she ventures no conclusion more dramatic than that Olivieri still wants deferiprone banned, despite accumulating evidence that her anxiety over its toxicity was an over-reaction.

Christopher Martyn *associate editor, BMJ*
cmartyn@bmj.com

Hit parade

bmj.com

These articles scored the most hits on the *BMJ's* website in the week of publication

MAY

- Editorial: Reducing knife crime**
BMJ 2005;330:1221-2
8204 hits
- This week in the *BMJ*: Try the new optimal strategy for searching Medline**
BMJ 2005;330 (21 May)
6869 hits
- Editorial: The polypill and cardiovascular disease**
BMJ 2005;330:1035-6
6703 hits
- Editor's choice: Triumph of the white male**
BMJ 2005;330 (7 May)
5974 hits
- Primary care: Effect of combinations of drugs on all cause mortality in patients with ischaemic heart disease: nested case-control analysis**
BMJ 2005;330:1059-63
5479 hits
- Paper: Optimal search strategies for retrieving scientifically strong studies of treatment from Medline: analytical survey**
BMJ 2005;330:1179
5367 hits
- Paper: Randomised controlled trial to compare surgical stabilisation of the lumbar spine with an intense rehabilitation programme for patients with chronic low back pain: the MRC spine stabilisation trial**
BMJ 2005;330:1233
4979 hits
- Paper: Optimal search strategies for retrieving scientifically strong studies of treatment from Medline: analytical survey [PDF version]**
BMJ 2005;330:1179
4585 hits
- Editorial: Clever searching for evidence**
BMJ 2005;330:1162-3
4288 hits
- News: English surgeons may at last be about to become doctors**
BMJ 2005;330:1103
3909 hits

All articles cited are full text versions unless otherwise stated.



The gateway to high society

Youth magazines are a useful indicator of emerging trends in teen drug use, a study suggests

Lifestyle magazines aimed at teenagers and young adults offer their readers mixed messages on drugs, invariably stressing the dangers of heroin and crack cocaine, while giving a more nuanced presentation of cannabis and ecstasy (3,4-methylenedioxymethamphetamine). A large number of drug references—about one third—in such publications are strictly neutral, striking neither a negative nor a positive attitude. These are some of the findings contained in a new thematic paper on the youth media published by the Lisbon based European Monitoring Centre for Drugs and Drug Addiction (EMCDDA (www.emcdda.eu.int/?nnodeid=10233)).

The authors examined 1763 references to drugs in 26 large circulation youth magazines published in five European Union member states—the United Kingdom, Ireland, Finland, Greece, and Portugal—over 10 months. Their research considered the extent to which this particular section of the media could provide information on new drug fashions and be used as a vehicle to prevent drug related damage to young people.

“Because of the hidden (illegal or illicit) nature of drug use,” says the report, “a time lag usually exists between the appearance of a new trend in illicit drug use and the production and dissemination of (authoritative) data about it.” That was certainly the case with ecstasy. Early accounts of its use in recreational and dance settings appeared in the mid-1980s in youth, music, and lifestyle magazines, but drug agencies only began compiling data on the phenomenon in the 1990s.

One difficulty in such a project is the wide disparity in the magazine market between countries. At the time of the research, Finland had 293 consumer magazine titles, Portugal 280, and the United Kingdom 2794, many of which are read across Europe. The study focused on the following, mainly monthly, publications: two trend/cutting edge, 13 general lifestyle, six dance music, and five targeted at other audiences.

Legal differences also exist in the way the issue of drugs may be handled in the media. Magazine editors interviewed in Finland, Greece, Ireland, and the United



JOE RAEDLE/NEWSMAKERS/GETTY

Ain't no stopping us now: drug use was seen as enabling users to stay awake to dance

Kingdom said that they were more constrained by public opinion, and the need to satisfy the interests of their readers and advertisers, than by any legislation. In general, their view was that it would be morally irresponsible when the wellbeing of their young readers was at stake to present a clearly positive image of any drug.

Some saw their publications, which were deliberately kept anonymous in the report, playing a part in reducing harm by providing information about drugs. But they all confirmed that the reason for including such material was popular interest and a focus on issues that were new, surprising, and humorous. They also denied supporting any politically driven pro-drug or anti-drug policies.

A detailed breakdown of the references revealed that cannabis and ecstasy were the most frequently mentioned drugs, receiving respectively 17% and 13% of all drug mentions, followed by cocaine (9%), heroin (8%), and hallucinogens (5%).

The advantages, mainly linked to cannabis, ecstasy, and alcohol, were most frequently portrayed as psychological—an aid to social identity—or physically energy enhancing, enabling users to stay awake to work or dance. Drug use was also presented as helping people to relax, communicate, or experiment. Most disadvantages referred to multiple rather than single dangers. These included acute physical, addictive, psychological, and legal risks. Despite the medical profession's growing concern about long term risks from ecstasy and cannabis use, these were raised far less frequently than acute risks.

However, feature articles specifically on drug issues often provided a mixture of both positive and negative drug information in a relatively evenly balanced way that readers might consider to be more objective. “Coverage of the risks and benefits of drugs such as cannabis and ecstasy . . . arguably provides more evidence-based information

about drug effects than the approach utilised for the spread of ‘moral panic,’ which focuses exclusively on negative aspects,” it suggests.

Drawing attention to the high number of drug references in magazines that target clubbers and to the high prevalence of drug use among that particular population, the study concludes that such publications can be a useful indicator of emerging trends associated with particular lifestyles. “Youth lifestyle magazines are sources for monitoring and triangulating evidence about drug trends. And the deeper understanding gained from youth media serves to inform the development of effective responses,” it notes.

However, the report is more cautious when assessing the extent to which youth media may influence the health related or risk taking behaviour of their readers. While it acknowledges that one school of thought claims that there is no link, it argues that evidence exists that suggests that readers' own self images are reinforced when faced with articles that interest, intrigue, inform, or entertain them. “Theories about diffusion of drug trends state that the more positive the image of a specific drug, the more potential there is for diffusion—provided there is relatively easy access to the drug.”

Commenting on the study, Wolfgang Götz, the EMCDDA's director, said: “While it is clear that the youth media provide valuable insights into the lifestyles of young people, the jury is still out on the extent to which they actually *influence* young people's behaviour. More work is required to study this influence and to determine how to constructively engage with media makers to explore the possible role of the youth media in communicating factual information on drugs to young people.”

Rory Watson *freelance journalist, Brussels*
rorywatson@skynet.be

PERSONAL VIEW

Are public inquiries losing their independence?

Public inquiries have played an important part in the NHS in recent years. Several major failures in our health-care services have been subjected to independent, public investigations, and the reports from those inquiries have had a wide ranging impact on health policy (*Health Affairs* 2004;23(3):103-11 and *BMJ* 2002; 325:895-900). Just before the UK elections in May 2005, the Inquiries Act 2005 slipped almost unnoticed on to the statute book. The government presented the act as primarily an exercise in legislative housekeeping—replacing the outdated Tribunals of Inquiry (Evidence) Act of 1921 and provisions for inquiries in various sector specific legislation like the NHS Act 1977, with a single, clear, and coherent set of provisions for establishing and undertaking public inquiries.

In reality, the new Inquiries Act gives government ministers unprecedented powers over the initiation, conduct, funding, staffing and direction of public inquiries. Ministers now set up inquiries by order (they used to have to seek a resolution in both Houses of Parliament); ministers appoint the inquiry chair and panel, and can add to or change appointments at any time; ministers write the inquiry terms of reference, and can change those terms of reference at any time; ministers can suspend inquiries, or terminate them early; ministers control inquiry funding and can withhold funding from activities that they consider to be outside the inquiry's terms of reference; ministers can restrict public access to inquiry hearings; and ministers (rather than inquiry chairs) are responsible for publishing inquiry reports and they can withhold parts of those reports from publication.

Overall, these changes seem designed to reduce the independence of future public inquiries, and to provide the government with a host of mechanisms for controlling

inquiries at every step. This is a considerable departure from past practice, in which the government took the decision to establish an inquiry and set its remit but then played absolutely no part in its subsequent development and progress, which were wholly in the hands of the inquiry chair.

Will this make for better public inquiries? It has been proposed that inquiries have six main purposes—establishing the facts, learning from events, providing catharsis for stakeholders, reassuring the public and rebuilding confidence, making people and organisations accountable, and serving the political interests of government (*Political Quarterly* 1999; 70(3):294-304). It seems that the new Inquiries Act certainly fits that final purpose, but at some cost to the others. It may be more difficult to find senior people with the skills needed to chair public inquiries, given the constraints now placed upon them. Inquiries

are likely to be more cautious and narrowly focused affairs, less able to pursue important issues which arise during the inquiry but which are not explicitly part of their original remit. Stakeholders are less likely to trust in the impartiality of inquiries

when government ministers are able to influence proceedings from behind the scenes, and so it is less likely that inquiries will produce cathartic exposure and closure for people who were involved or affected.

The most fundamental and important characteristic of public inquiries in the United Kingdom has been their independence. By owing no allegiance to any stakeholder and especially not to the government that sets them up, and by having the freedom to investigate openly and impartially and to report without censorship, inquiries have been able to build consensus and command widespread support for their findings and recommendations. It remains to be seen whether this government, by taking so many new legislative powers to control and direct public inquiries, has stripped them of the independence and impartiality that was so central to their purpose.

Kieran Walshe professor of health policy and management and director, Centre for Public Policy and Management, Manchester Business School
Kieran.Walshe@man.ac.uk

We welcome submissions for the personal view section. These should be no more than 850 words and should be sent electronically via our website. For information on how to submit a personal view online, see <http://bmj.com/cgi/content/full/325/7360/DC1/1>

SOUNDINGS

Death and taxes

"He was just so excessively Scottish, which was an unexpected treat, and polite . . . but terribly firm. 'Unfortunately the Inland Revenue does not recognise the state of dying, sir,' he said. I felt like asking him if I should come back when I'm dead . . . He was exactly the sort of person it might be quite fun to haunt. Then he came over all sympathetic, but still wouldn't give an inch. 'I'm afraid we still need that tax return, as I'm sure you'll understand, sir.' Actually that sort of stuff's the easy bit . . . Some of the rest is difficult. You'll know all about my new friend giardia? *Giardia lamblia*?"

He said it again in comic-waiter Italian, launched into an instantly surreal menu explaining riff that had me laughing out loud, and then said quietly, "But it's awful. I mean quite the worst thing about dying, so far at least. Basically, it's nappies from here on in . . ."

We chatted for a few minutes more, then he said goodbye. Three weeks after our phone call his funeral, in a little church on the remote Solway coast, was a strange reunion for a raffish Edinburgh student set from the mid 1960s: by then—it was 20 years on—almost uniformly respectable. Unused to funerals for people our age, we sang the hymns and listened to a cautiously worded tribute, then decanted into the churchyard in light rain for what the order of service called the interment, in a grave with a lovely view of the sea.

HIV had caught him early, when death was still routine. With better luck, or even with bad luck later on, he would of course still be alive today: amusing and amiable and probably still working and paying his taxes, one of the fortunate tens of thousands in the developed world now saved by highly active antiretroviral therapy from what he himself called at the time rather a shitty death.

Another 20 years on, many millions of people—many of them in sub-Saharan Africa—are dying shitty deaths like his, though with the important difference that they are now preventable.

I write this in Edinburgh, where last Saturday 200 000 people turned out in a polite and probably futile pre-G8 attempt to influence the thinking of "eight rich guys on a five star golf course." Among other things, those marching innocents believed that something useful—based on tax dollars and drugs that could easily be far cheaper—might still be done to prevent such deaths. I am not so optimistic.

Colin Douglas doctor and novelist, Edinburgh



PHIL NOBLE/PA/REXUS

Inquiries are likely to be more cautious and narrowly focused